California Health Policy and Data Advisory Commission
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CALIFORNIA HEALTH POLICY AND DATA ADVISORY COMMISSION
June 15, 2004

Chairman, William Weil, called the meeting to order at 10:20 a.m. at the U.S. Grant Hotel in San Diego, California.

Commissioners Present:	Absent:
William S. Weil, MD, Chair	Paula Hertel, MSW
William Brien, MD	Corinne Sanchez, Esq.
Marjorie Fine, MD	M. Bishop Bastien
Sol Lizerbram, DO	Howard Harris, PhD
Hugo Morris	Janet Greenfield, RN
Jerry Royer, MD, MBA	
Kenneth Tiratira, MPA	

CHPDAC: Jacquelyn Paige, Executive Director; and Raquel Lothridge, Executive Assistant
OSHPD: David M. Carlisle, MD, PhD; and Mike Kassis, Deputy Director, Healthcare Information Division
Other: Vito Genna, Chair, Health Data and Public Information Committee; and Darryl Nixon, HDPIC/California Association of Health Facilities

Chairman's Report: Dr. Weil reported that Howard Harris injured his shoulder, and returned to Sacramento for medical care.

Travel claims for this fiscal year, July 1, 2003 through June 30, 2004, should be submitted to the Commission Office by June 30.

Executive Director's Report: Anthony Wright, Executive Director, Health Access, and Beth Cappell will be making presentations about the charge master and other health information issues of importance to their association and consumers at the August 20 meeting. Health Access was a sponsor of the charge master legislation. Also speaking at the August meeting will be Ninez Ponce, a UCLA investigator involved in the California Health Information Survey efforts. Ms. Paige summarized some of the publications that have come across her desk recently, and asked that Commissioners interested in receiving copies of particular publications sign the front cover and copies will be sent to them.

Approval of Minutes: The minutes from the April 20, 2004 meeting were approved.

OSHPD Director's Report: Dr. Carlisle reported that discussions have been held

with the Health and Human Services Agency Secretary regarding policy on seismic safety. The Office received a major budget augmentation of 50 positions to support and conduct hospital plan review functions within the Facilities Development Division. The Office is awaiting finalization of the budget before filling the positions. At the end of last year, 19 positions were granted (included in the 50 total), of which 17 positions have since been filled. There is a shortage of fire/life safety officers. In the past, structural engineer positions were the challenge to fill but that is not currently the case.

One of the legislative bills which the Office is following very closely is AB 2973 (Cohn), which would place an upper limit on the amount of processing time that the Office could take to review applications for construction projects more than $50 million in size. These are massive projects, which are essentially original hospital remodeling or reconstruction from the ground up. The initial Office review period would become 90 days, and the subsequent review period would be 60 days. Previously, it took the Office approximately one year from submission to final approval on a project like this. It is estimated that it now takes about one year and a half to complete the review process.

The bill appears to be headed toward an amendment to make it 90 days. The bill also would establish an independent plan reviewer to look at construction plans before submission to the Office to certify that plans are consistent with California building codes. Hospitals have this ability now, but not all exercise this capability. Some large entities have consultants review construction plans before submission to the Office. This process would streamline the review process for California facilities.

SB 1487 (Speier) would require hospitals to collect data regarding nosocomial infections. It is estimated that there are over 8,000 deaths per year in California due to these infections, and 90,000 deaths nationwide. It has been said that one in 20 patients discharged from a hospital in the United States may acquire a nosocomial infection. These infections would be reported quarterly to OSHPD beginning in 2006. Upon receipt of the reporting of hospital-acquired infections, the Department of Health Services would initiate inspections to determine whether the health or safety of patients is at risk in a given facility. The bill is now out of the Senate and is before the Assembly.
Mr. Kassis said over a six-year period, total cost of reporting would be about three million dollars, with ongoing costs of about $250,000. The start-up costs would consist of modifying the data collection system to capture these data elements, and for outreach to hospitals to report in some standardized way.

SB 379 (Ortiz) and AB 232 (Chan), both dealing with charity care, are in the second house. SB 379 would require hospitals to develop charity care and reduce payment policies. AB 232 would require hospitals to develop a policy regarding self-pay and under insured patients, and establish self-pay prices that would not exceed the amounts paid by Medicare, Medicaid, or Worker's Compensation for the same services. It would also require OSHPD to collect uniform self-pay application forms used by each hospital and would have authority to develop a uniform application form. There has been no recent activity on either bill.

SB 2876 (Frommer) would impact OSHPD's data reporting authorization. The Information Practices Act specifies the entities that can receive public and confidential data. Historically, hospitals were not specified, but have had access to the data. This bill would authorize

OSHPD to report data that is not confidential to hospitals, or a middle group of data that could be used for utilization review and reporting. This bill was referred to the Assembly Health Committee and Assembly Committee on Judiciary because it deals with the issue of privacy. It has passed out of the Health Committee and is pending in the Senate.

At the last Commission meeting, Commissioners asked about legal authority to advise the Office on legislation. The Commission is advisory to the Office, and can advise the Office on how to evaluate specific pieces of legislation. Recommendations are made to the Office, and the Office acts as part of the Administration.

The legislative process is highly dynamic, and legislative amendments to a bill are made rapidly. Because of the Commission's two-month meeting schedule, the opportunity for monitoring and providing input is often lost. The best time for input could be when a bill is being drafted or first introduced. Legislators are aware that they can ask for technical assistance from State Departments, and frequently do ask. OSHPD analyzes legislation when it is introduced, and when it is on the Governor's desk for signature or veto.

Dr. Carlisle emphasized that technical assistance is different from providing advisory input. No advice is given to members of the Legislature on bills. OSHPD's only responsibility is to provide technical assistance on operational and other informational details. It was suggested that an early meeting at the beginning of the legislative year be devoted to legislation, which might affect the Office. Commissioner Morris thought that the Commission should have a practice of inviting key legislators to Commission meetings.

The charge master bill is summarized below:

Patients, consumer groups, employers, and health plans would be provided access to prices charged by hospitals for goods, services and procedures.

Health plans and purchasers would be able to compare these charges for highly specific services and procedures.

Public awareness, as far as prices/charges, would be enhanced by the provision of information.

OSHPD would compare the average charges for the ten most common DRGs. This would be of assistance to patients, consumer groups, payers, employers and health plans.

It is recognized that the charge description master does not provide the exact price associated with medical services, which would be reflective of goods, services, competition, etc., in the marketplace.

Neither the charge master nor any other document will necessarily capture how much a third party will pay for billed services, unless contractual relationships between third parties and hospitals are actually examined.

The understanding of the charge master requires a very sophisticated knowledge of medical terminology and how charges are designed within hospitals. The charge master may be too

complex to understand for the average consumer.

These issues were discussed in the Legislature prior to the bill's enactment into law. Supporters of the charge master were: Health Access, Public Employees Retirement System, Consumers Union, Service Employees International Union, California Nurses Association, Western Center on Law and Poverty, American Federation of State, County and Municipal Employees, and California Independent Public Employees Legislative Council.

The community-acquired pneumonia report has been approved by the Administration and will be released shortly. The use of do-not-resuscitate (DNR) orders and condition present at admission (CPAA) were used in the outcome model and reported for the first time in a report. This is a significant step forward in outcome modeling.

The Governor's budget supported the continuation of the Song-Brown program, the Family Physician Training Program. The General Fund has supported the Song-Brown program since 1973. For the coming year, it was proposed that the Health Data Fund, which supports the information collection activities, support the program. In addition to supporting the Song-Brown program, OSHPD is implementing regulations to reduce the assessment fee paid by hospitals into the Health Data Fund. As a result of the Song-Brown funding, the beginning reserve fund will have a little less than a million dollars. At the last Commission meeting, there were issues about the reserve being too large and therefore the reason for the reduction of fees, not suspecting that the Legislature would make a decision to keep the program within OSHPD but change its funding source to a special fund. Commissioners voiced their concern about reducing the fee for any length of time.

At the budget hearing, it was the position of the American Family Practice Association and the California Healthcare Association that the Song-Brown program should be supported by General Fund money. The funding of the program is for one year. OSHPD was asked to return at a later time to the budget subcommittee with alternative funding methods to support the Song-Brown program. Suggestion was made to try foundation funding. It was said foundations are reticent to support long-term governmental programs that are removed from support by the General Fund budget.

Health Data and Public Information Committee: Vito Genna reported that the HDPIC met on May 21. A presentation was given on the Geographic Information System (GIS) program, a zip code driven system that allows for easy regional analysis, which can have important public policy ramifications. The Committee asked for periodic updates on GIS activities. GIS allows OSHPD to take disparate data sets and put them into a geographic framework, layering them together to get a fuller picture of activity in a given area. Privacy issues were discussed because by using utilization information, profiles of individual communities and cities can be shown.

It was announced that the California Health Information Association will give an award to OSHPD for the implementation and integrity of the data collection activities.

The rest of the meeting dealt with charge masters. The Committee was asked to continue to discuss the new charge master. Richard Thomason, principal consultant to

Assemblyman Frommer, was present at the meeting and cited the rationale for the enacted legislation, which came out of hearings looking at the billing practices of Tenet Healthcare and probable gaming of the system. The purpose was to make charge masters more of a public document and give more information about the levels of charges at different hospitals. He felt consumers would be more interested because health plans also cost shift, and it is said there will be higher deductibles. He made it clear that this is a starting point, and thanked OSHPD for technical help while the legislation was being written.

There was discussion about how to implement and collect the information to avoid a resource drain by the hospitals or OSHPD, and OSHPD's role as a middle person basically to collect and disseminate the information. Concern was expressed that manpower resources utilization takes away from other good programs, like GIS.

Facilities in year two will estimate the percentage change in gross revenue from a price change, price increase. It was decided that facilities would submit their charges, the charge master, as of June 1 on a yearly basis. The mandate has been given to collect the information, and OSHPD will implement it as easily as it can, at least for the first couple of years. After the first year, there may be other ways identified to make collection better.

Facilities will also submit their list of top 25 services or procedures to OSHPD. The first year will not be consistent; OSHPD has the authority to set the list for the 25 service or procedures for the subsequent years. Consideration has been given to small, rural facilities and these lists may be different.

The HDPIC made recommendations to modify the proposed regulations, to have an as-of-date and to limit the electronic format of the reporting to OSHPD. The proposed regulations given to Commissioners have been modified to include these recommendations that the Office received and appreciated from the committee.

After some discussion, a motion was made by Commissioner Tiratira and seconded by Commissioner Lizerbram to support the proposed charge master regulations. A public comment period will follow before submittal and approval by the Office of administrative Law. **Motion passed**. Commissioner Fine opposed the motion, and Commissioner Royer abstained.

Technical Advisory Committee: Dr. Royer reported that the TAC met on May 26 and heard updates from OSHPD Director Carlisle, the Healthcare Information Division, and the Healthcare Quality and Analysis Division. Dr. Carlisle reported on the California Performance Review (CPR) process and the Little Hoover Commission, which are trying to streamline and increase the efficiency of State Government. Two years ago, the Little Hoover Commission recommended the creation of a separate Department of Public Health, which may or may not include OSHPD. A CPR report is expected soon.

There has been concern about the aging of data used in the outcome reports. The pneumonia report to be released shortly will contain data from years 1999 to 2001. The studies to date have been based on validation of data. For the first time, there was an issue with contractor performance and deliverables not being produced by the time specified in the contract. OSHPD has been working with the contractor and a report is expected soon.

With MIRCal, the aging of data will be less of a problem, since reports will be produced more quickly.

There was discussion by the TAC about appending or adding information on the PEP-C survey to the maternal outcomes report. Only about one half of the state's hospitals participate in PEP-C. There are still methodology problems about that approach. The TAC recommended not including the PEP-C survey data.

The next acute myocardial infarction (AMI) report is expected to be released in 2005, and will contain data from 2002 through 2004.

Intensive Care Units (ICUs) are the highest mortality unit in the hospital, and use ten percent of the hospital budget. Both Leap Frog and the Joint Commission on Accreditation of Hospitals have focused on ICU care. Leap Frog is considering requiring that one element of accreditation is an ICU performance measure. The Joint Commission would like to add ICU as a fifth core measure in evaluating and accrediting hospitals, and is looking to OSHPD as to the method of measurement. Instead of looking at a single disease or single procedure, many different diagnoses that come into an ICU can be analyzed.

One of the objectives of the California Intensive Care Outcomes (CALICO) was to evaluate four models to evaluate the discrimination, and see how useful, accurate and robust the systems were when looking at quality of care. All of the vendors collect many data elements in the ICU. The question is a balance between the model performance and the extra cost of collecting all these additional measures. It was felt that the four models were not adequate, and each had outliers both in higher mortality than expected and lower mortality than expected.

There was some discussion about whether OSHPD should use the 15 additional data elements on this project. If the Joint Commission mandates hospitals to collect this data, then the 15 data elements would not be spent on this collection.

The study only included adults over the age of 18 years and the variables collected included crime health status, physiology, acute diagnosis and other, as well as do-not-resuscitate and condition present at admission.

Some of OSHPD's outcome reports are aimed at more elective procedures such as CABG, which may influence the choice of hospital or physician. There is no choice of where to go when a heart attack occurs. CALICO is trying to capture global quality of care, and captures many conditions. A majority of unanticipated mortality in a hospital, especially non-elective circumstances, probably goes through an intensive care unit. Insight into the performance of a hospital can be gained by analyzing its most critical patients. There is quite a spread in adjusted mortality across intensive care units, which has importance and implications in understanding how quality of care can vary across institutions in a variety of settings. This would give a handle to the performance of inpatient services across California hospitals.

A major methodological challenge of continuing the CALICO study is to fully capture the variation and sorts of services, which might be provided to terminal or pre-terminal patients by not aggressively treating these patients.

The oldest of the four outcome models was developed almost twenty years ago and what is being done in ICUs has shifted technologically since that time. All of the models are somewhat obsolete now. CALICO recalibrates many of the variables and makes them more up to date in terms of their performance.

The Commissioners thought that trauma aspect is important to look at because it crosses all lines. Condition present on admission can be identified through a variety of different measures that are used. It was uncertain whether trauma was included in CALICO.

Much of the care and outcomes is based on what happens in the emergency department when a patient comes in, and followed through the ICU. Emergency department care is critical and depends on how quickly professionals can respond with the various treatments that need to be used. If the right model is used, one should be able to see how well the ICU does, given this set of data.

During the discussion of the emergency room and ambulatory surgery data collection regulations, a concern was expressed that when a person is seen in the ER and discharged, there is an ER record. If a person is seen in the ER and admitted, there is a hospital record, but no separate ER record. Mr. Kassis said his staff has been working with other states to determine how this problem is handled and look at ways to refine the data system to capture this information. Dr. Fine said the ER usually retains its own record, and the information might be obtained directly from the ER.

AHQR has developed a set of measures for outcomes that could be applied to inpatient care and has encouraged states to develop outcome models based on these measures. The difference between these quality indicators (PQIs) and OSHPD's outcome report models is that they are based entirely on administrative data and do not use validation to ascertain the quality of the data. Historically, OSHPD has used validation studies to ensure good data. OSHPD feels the quality of its administrative discharge data set now is sufficiently high (and has been tested) and performs well in comparison to the clinical medical record derived data set.

OSHPD is exploring whether to expand the breadth of the outcome studies using administrative data set without doing validation studies when new models are developed. The number of outcome studies could easily be expanded from the current five if validation studies were not done. The TAC will discuss this notion further.

<u>AB 1075 Medi-Cal Nursing Facility Reimbursement Reform</u>: Darryl Nixon, California Association of Health Facilities and Vito Genna, California Association of Homes for the Aging

Mr. Nixon represents the long-term care facilities, the nursing homes that are run by the private sector. This is about 55 to 60 percent of all long-term care facilities, with about 75,000 LTC beds, some of which are not-for-profit, but primarily for-profit. Mr. Genna represented the not-for-profit sector in the discussion.

California is one of a few states that currently has a flat rate reimbursement system. Every

nursing facility receives the same rates, with some exceptions because there is a geographic or size differential. The three geographic areas are Los Angeles County, the Bay Area, and all the others.

The flat rate system has done a good job in controlling costs, but has not done a good job of providing a means to improve quality. The Legislature and Governor recognized when AB 1075 was enacted in 2001, that reimbursement was one of the issues that were impeding California's progress in improving the long-term care system. The flat rate system is not facility specific, but peer grouped. All costs are aggregated into a single bucket, with some minor exceptions, and then facilities are rated in each peer group from high to low. The median facility determines the rate.

Primarily 65 percent of the patients in California in LTC are paid by Medi-Cal, 10 percent by Medicare, with the balance made up of a combination of HMO patients, long-term insurance, and private pay. Private pay probably comprises about 10 percent of the balance versus insurance.

AB 1075 was enacted to develop staff to patient ratios for direct caregivers, and was supposed to take effect on August 1, 2003, but did not happen for the following reasons:

First, long-term care has struggled with staffing shortages, both in the CNA side and the licensed side.

Second, Medi-Cal is the payer of 65 percent. There is an incremental cost difference of moving from a current 3.2 average hours to staff to patient ratios. The transition was supposed to take effect, then the Department of Health Services would analyze every five years whether there needed to be incremental increases in the staff-to-patient ratios. The ratio was based on national studies, calling for an average of about 4.1 hours of direct care, compared to 3.2 in California. This would be a substantial cost difference.

The requirement for reimbursement reform was to have a facility-specific rate setting system in place by August 2004, which reflected the cost of staffing levels, associated with quality of care for residents. DHS was to submit periodic reports to the Legislature upon implementation. In December 2002, there were large stakeholder meetings comprised of consumer advocates, labor, and industry representatives. Since July 2003, CAHF has been working closely with a labor group and some of the largest corporate firms in California, and a proposal has been submitted to the State.

In trying to design a new system, included were incentives conducive to quality of care. Appropriate cost controls were wanted, as well as administrative oversight to eliminate waste, fraud and abuse. It is difficult for providers to comply with state and federal requirements when new costs arise and are not adequately addressed in the reimbursement system and administrative efficiency.

The group of labor and industry representatives, in looking at the need and the requirements of staff to patient ratios, felt that the type of model should be one primarily driven on the labor costs that it takes to provide the care. A labor driven model would better support the work force guiding principles to ensure a highly trained work force, in sufficient

numbers, allowing for advancement of wages, benefits and other professionals. The model included major cost components: labor, property, capital, care-related non-labor, return on income, and direct cost factors. Two years ago, a number of the major chains were in bankruptcy, and some of the not-for-profits tapped into their endowments. There needs to be the ability to replenish working capital.

Dr. Fine said in looking at the population demographics, there is an aging generation, unlike prior generations where families took care of the elderly, with many single people who will have nobody to care for them when they are aged, and/or have a terminal illness. The industry is being squeezed to not have beds available and this will be a major problem.

There has been a shift in the industry with nursing home chains going into assisted living to bring down costs, because there are fewer regulatory issues. There are borderline nursing home patients being taken into care in assisted living facilities. The GAO report pointed out the need for greater regulations. Many persons in assisted living should be in intermediate care. If there is a layer of regulations on top of assisted living, there will be a similar problem to that of nursing home care, with lost beds.

The industry would like to see Medi-Cal pick up 100 percent for things the facility has no control over, for example license fees, property taxes, caregiver training, provider assessments, and liability insurance. There is much litigation under the elder abuse act, and malpractice insurance rates have risen. Insurance companies have begun to leave California. Some facilities are going without liability insurance.

Question was asked if there was a way to absorb this as a cost savings on Medi-Cal similar to that of a VA hospital where a patient cannot sue the government. Could the State provide an insurance policy? Mr. Nixon said the reform package does include some liability and regulatory reform. A dedicated payment source such as the tobacco tax could be lobbied or seek enhanced federal participation, currently a 50/50 match. Other impoverished states receive a higher match. A recent GAO report found disparity across a number of large states and said something should be done about it.

Some states use a controversial provider assessment, or quality enhancement fee, to enhance the state general fund. This would mean charging everyone a tax, or shifting the cost. Currently 21 states have such fees in place, with 12 others currently seeking approval from the Federal Government. The fee can be included as an allowable cost for the Medi-Cal patient; therefore the Federal Government will also pay for their proportionate share of the fee. It has been proposed that Medicare be eliminated from hospital-based facilities and facilities run by state or local governments, which federal law allows. Medi-Cal facilities are required to ensure that the private pay rate is not less than the Medi-Cal rate. Those manipulating the system, such as transfer of assets to qualify for Medi-Cal, will create a greater strain on the system.

The Commission and OSHPD could help remedy the situation by disclosing the data collected by OSHPD. Data could include discharges and where patients are going (home, rehabilitation, etc.) and payer (private pay, Medicare, HMO, etc.).

OSHPD can be helpful by participating as a stakeholder with the Department of Health

Services to encourage more timely and accurate reporting. It has been suggested moving to quarterly reporting and an online system. The current system is annual reporting based upon a facility's fiscal year, and by the time it gets online the data are about 18 months old. The utilization reporting is annually, and can show trends. LTC reports are available as unedited data as soon as it passes computerized checks.

Deputy Director Kassis has made a commitment to meet with LTC facilities, home health, and clinics and review the contents of various reports to determine the most useful data. There is federal data through licensing and certification, but DHS does not disseminate it. Mr. Nixon liked the idea of requiring facilities to report the same information to OSHPD. An issue is the ownership of the data, and using the data more than once by an agency. It was suggested that a meeting be held to present the LTC data available, with both OSHPD and DHS giving presentations. Mr. Kassis said he would like to link minimum data set (MDS) with the death file, where a 30-day mortality could be reported. There probably should be data reporting from the assisted living industry.

Discussions on long-term care, including a presentation on OSHPD long-term care data will continue at future meetings.

Adjournment: The meeting adjourned at 3:08 p.m.